105th Congress
2d Session

HOUSE COMMITTEE PRINT NO. 4

REPORT

TO THE

COMMITTEE ON THE BUDGET

FROM THE

COMMITTEE ON VETERANS' AFFAIRS

SUBMITTED PURSUANT TO SECTION 301 OF THE CONGRESSIONAL BUDGET ACT OF 1974

ON THE

BUDGET PROPOSED FOR FISCAL YEAR 1999

WITH ADDITIONAL AND DISSENTING VIEWS

MARCH 24, 1998.—Printed for the use of the Committee on Veterans' Affairs of the House of Representatives

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, March 24, 1998.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Enclosed are the views of the VA Committee on the budget for veterans benefits and services for fiscal year 1999. The Committee is unanimous in its view that the President's budget proposal is inadequate to honor the commitment we have made to our nation's veterans. Significant shortfalls are identified in the proposed budget for:

- veterans medical care, which cannot keep up with veterans' demands for services if the only projected increase in funding is collections from third parties;
- benefit claim processing, because of recently identified problems with the quality of VA decisions and continuing concerns over the timeliness of VA's response to veterans seeking benefits; and
- facilities and infrastructure replacement and modernization to ensure patient safety and develop requisite capacity for shifting care to an outpatient basis.

The Committee is pleased to recommend additional resources to address these matters. In addition, the Committee recommends funding to increase oversight of the VA's medical quality assurance program and overall review of agency programs by the VA Inspector General. We believe that significant quality and efficiency gains can result from a small investment in these areas.

Finally, although we differ as to whether the Congress should enact legislation modifying the eligibility for VA compensation benefits for tobacco-related diseases, we strongly believe that any "savings" from enacting such legislation should properly be used to restore and improve programs for veterans.

Sincerely,

Bob Stump,
Chairman

Lane Evans,
Ranking Democratic Member

Summary Table: Estimates of Committee on Veterans' Affairs For Fiscal Year 1999 Budget [Net Budget Authority– $ in million]					
Department of Veterans Affairs	**FY 1997**	**FY 1998**	**FY 1999 Admin Request**	**FY 1999 Committee Recom.**	**Comm. +/- Admin.**
Veterans Benefits Administration					
Compensation and Pension	19,599	20,483	21,857	21,857	0
Proposed Legislation*				0	0
COLA			287	287	0
Tobacco			-400	-400	0
Readjustment Benefits	1,377	1,366	1,175	1,175	0
Proposed Legislation		0	291	400	109
Housing Programs	657	1,036	423	423	0
Proposed Legislation*	0	0	-2	0	2
All Others	40	52	47	47	0
					0
Subtotal, Veterans Benefits	21,673	22,937	23,678	23,789	111
Veterans Health Administration					
Medical Care					
Appropriation	17,012	17,057	17,028	17,509	481
Medical Care Collections Fund	0	688	677	559	-118
Proposed Legislation	0	0	87	0	-87
Subtotal	17,012	17,745	17,792	18,068	276
Medical & Prosthetic Research	262	272	300	300	0
MAMOE	61	60	60	62	2
State Homes & Parking	60	80	37	80	43
Subtotal, Veterans Health	17,395	18,157	18,189	18,510	321
Department Administration					
Construction, Major Projects	219	209	97	237	140
Construction, Minor Projects	175	175	141	175	34
Subtotal Construction	394	384	238	412	174
VBA	626	596	651	672	21
General Administration	202	191	199	200	1
Subtotal GOE	828	787	850	872	22
National Cemetery System	77	84	92	93	1
Office of Inspector General	31	31	33	36	3
Grants for State Cemeteries	1	10	10	10	0
Subtotal, Department Administration	1,331	1,296	1,223	1,423	200
Total, DVA, adjusted	40,398	42,390	43,090	43,722	632
Trust funds, net	1,067	1,025	968	968	0
Proprietary receipts, adjustments, and intragovernmental transactions	-1,667	-675	-685	-685	
Total, Department of Veterans Affairs	39,798	42,740	43,373	44,005	632

INTRODUCTION

The Veterans Population

Between 1997 and the year 2010, the number of living veterans is projected to decline from 25.4 million to 20 million, a decline of 21 percent. The largest group of living veterans by period of service is the Vietnam era population of 8.2 million veterans, followed by the World War II group of 6.7 million veterans. The number of veterans 65 years and over is expected to peak in the year 2000 at 9.3 million. The number of veteran deaths will increase each year until a peak of 620,000 deaths is reached in 2008.

Projected Number of Participants in VA Programs, FY 1999

Program	Participants	Program	Participants
Medical Care:		Vocational Rehabilitation:	
Unique Patients	3,413,000	Veterans Receiving Services	52,200
Compensation:		Loan Guaranty:	
Veterans	2,361,900	Loans Guaranteed	222,000
Survivors/Children	307,400	Insurance:	
Pension:		Administered Policies	2,275,800
Veterans	390,100	Supervised Policies	2,465,000
Survivors	283,000	National Cemetery System:	
Education:		Interments	80,300
Veterans and Servicepersons	309,900	Graves Maintained	2,322,400
Reservists	76,400	Headstones and Markers	336,500
Survivors/Dependents	43,000		

Spending for Veterans

In 1950, the veteran population was just over 19 million and Federal spending for veterans benefits and services comprised almost 21 percent of the total Federal budget and was equal to 3.24 percent of the gross domestic product (GDP). In that same year, veterans benefits made up more than 62 percent of the category of spending known as "human resources", e.g. spending for education, health, and social security. By 1965, spending for veterans benefits had declined to less than one per cent of GDP, and it has been around one half of one percent since at least 1985.

In the most recently completed fiscal year (1997), spending for veterans benefits and services had shrunk to 2.5 percent of total Federal spending, and equaled one-half of one percent (0.5 percent) of GDP. Veterans benefits comprised only 3.9 percent of Federal spending for human resources in the same year. Outlays for mandatory veterans benefits (mainly compensation, pension and education benefits) are projected to fall from 13.4 percent of all federal mandatory outlays in 1965 to 2.8 percent of such outlays in 1999.

Comparing spending for veterans' health care needs reveals a similar picture. In 1965, the year in which Medicaid and Medicare were created, spending for veterans health equaled roughly 40 percent of total Federal health spending. A decade later, spending for

veterans health was less than 10 percent of spending on Medicaid and Medicare. In 1997, the $17.1 billion spent for veterans health was 5.4 percent of Federal spending on Medicare and other health programs, and this percentage will continue to decline if present fiscal trends continue.

The Administration's 1999 budget assumes that the federal government will receive approximately $65.5 billion from tobacco companies in connection with pending legislation to approve a tentative settlement agreement between various state attorneys general and major tobacco companies. Given the billions of dollars expended each year by the VA to provide health care and other benefits to veterans suffering from tobacco-related illnesses, it is the Committee's view that the VA and the veterans it serves should receive significant proceeds from any such settlement. The Committee is disappointed that the Administration's budget fails to directly provide any settlement proceeds for the VA, and intends to take necessary action to ensure that VA receives funds from any tobacco settlement that is approved by the Congress.

PROJECTED SPENDING FOR VETERANS BENEFITS AND SERVICES (FUNCTION 700)

(Budget Authority in billions of dollars)

	1998	1999	2000	2001	2002	2003	1998–2002
Mandatory	23.8	23.9	24.8	25.6	26.2	27.6	151.9
Discretionary	19.0	18.9	18.9	18.9	18.9	19.6	114.2
Total	**42.8**	**42.8**	**43.7**	**44.5**	**45.1**	**47.2**	**266.1**

Effects of the Balanced Budget Act on Spending for Veterans

The table above shows the projected spending levels for veterans benefits and services under the budget agreement reached in 1997. The totals shown for discretionary spending do not include amounts which VA would be authorized to spend for medical care as a result of keeping receipts which were previously deposited in the Treasury. CBO estimates these receipts will range from $542 million in 1998 to $615 million in 2002. Since spending will equal the amount collected, a bookkeeping convention excludes these amounts from the total shown for discretionary spending.

Under the budget agreement, discretionary spending for veterans benefits and services is projected to remain almost constant at the 1998 level of $19 billion. Mandatory spending is projected to rise slightly over the next five years, from $24 billion in 1998 to $26.5 billion in 2002, an increase of about 2 percent a year over this period. Overall spending for veterans benefits and services would rise from $43.1 billion to $45.4 billion, an annual rate of increase just over one percent (compared with a projected 2.3 percent annual increase in overall Federal spending for the same period).

BACKGROUND AND COMMITTEE RECOMMENDATIONS

Department of Veterans Affairs

VETERANS HEALTH ADMINISTRATION

Medical Care

"Change" and "transition" continue to characterize the state of the VA health care system. At all levels, the Veterans Health Administration has undergone major reorganization. Statutory changes and new policies continue to be implemented, primarily through VHA's 22 network offices, which to varying degrees have exercised decentralized authority to make their mark on the provision of care in their respective geographic service areas. Among the changes still underway are:

- reductions in the number of acute care beds (down 40 percent or some 21,000 beds since September 1994) and a decline in annual inpatient admissions of some 250,000/year;
- an accompanying increase of 7.3 million ambulatory care visits in the last three years;
- further reallocation of medical care funds from networks of facilities serving a shrinking patient base to those whose funding had not kept pace with veteran population growth;
- redirecting resources—from merging hospitals, closing hospital wards, and other efforts at improving productivity—to establish new community-based outpatient clinics (some 150 have been established);
- implementation of new health-care eligibility rules, which will require enrollment of most veterans as a condition of their receiving care;
- development of a national formulary for pharmaceuticals and other efforts to achieve economies of scale to increase VA purchasing power;
- efforts to increase reliance on non-appropriated funding sources.

With greater efficiencies at VA facilities and accompanying changes in practice patterns, more emphasis has been placed on providing veterans have gained increased access to primary care. These ongoing changes also pose a large challenge for VA managers at all levels to assure that VA effectively employs its resources—budgetary and otherwise—to meet the needs and expectations of a complex patient population.

As the Department wrestles with the complex management challenges associated with major system changes, VA must also grapple with a difficult fiscal challenge. No longer is the VA's congressionally appropriated medical care budget the sole source of needed revenue to support the health care system. With the establishment of authority for VA to retain collections and fees in the new Medical Care Collections Fund and use those funds to supplement medical care appropriations, Congress has given VA a powerful new incentive to maximize collections. It has been clear, however, that the primary source of those supplementary funds are third-party collections, primarily from health-care insurers.

The fiscal year 1999 budget is dependent both on the Department's increasing substantially the revenues generated through its recovery efforts and on its ability to function effectively with medical care appropriations which not only do not increase, but would be $29 million below the 1998 appropriation level. Consistent with the budget agreement approved by Congress last year, the Administration, in effect, asks Congress to make two huge leaps of faith in advancing this budget for VA medical care. First, it asks Congress to believe that VA will increase its medical care collections more than $100 million above the 1998 level, a level which the Congressional Budget Office projects will increase only slightly in 1999. Even more significantly, it urges Congress to concur in the blind faith that VA can wring *more than $680 million* in savings out of its medical care system—by absorbing fixed cost increases and the impact of inflation—without any adverse effect on its medical care to veterans. Those savings would come on top of savings squeezed from the same system in the prior fiscal year.

As described above, the VA has made dramatic changes in its health care delivery system. Many of the changes have been positive. Facilities in close proximity have merged. Redundancies and unneeded positions have been eliminated. Underutilized hospital wards have been closed, reliance on outpatient care has been expanded. In the aggregate, indicators of quality have improved.

But budget-driven cuts have not been without impact on VA's patients. Pressures to reduce costs have resulted in:

- medical centers cutting valued staff in needed programs including blind rehabilitation, prosthetics, spinal cord injury care and similar special programs which Congress in Public Law 104-262 explicitly required VA to protect;
- medical centers closing needed but costly-to-operate VA nursing home beds or placing restrictions on the number of nursing home bed days veterans can receive;
- medical centers cutting home-health and other services to veterans; and
- instances of VA practitioners being required to cease using expensive medications and to limit the time spent with any patient to a matter of minutes.

While such situations are not occurring at every VA facility, they are neither isolated events nor matters of hearsay. With VA facilities under unyielding pressure both to cut costs and to increase the numbers of veterans served, it is apparent that the changes underway are not wholly "seamless" or painless to patients who require more than primary care services. In a system which has decentralized authority to 22 network offices and has eliminated the requirements and much of the means for national oversight, VA headquarters itself no longer knows where individual patients are falling through the cracks created by budget pressures. This Committee finds increasing evidence, however, that some facilities have already squeezed out what savings can reasonably be achieved and cannot keep doing more with less spending power—except at the expense of the care provided to veterans. With growing signs that the system cannot sustain "no growth" budgets without endangering needed programs and compromising care or access to needed

services, this Committee rejects the Administration's overconfident view that veterans can rely on "anticipated management efficiencies" to offset in their entirety increased costs of such magnitude.

In addition to that concern, the Administration budget projects that gross fiscal year 1999 collections will total $677 million, a hefty increase over a current estimate for FY 1998 of $598 million. Such efforts at estimating have proven unreliable in the past; in fiscal year 1997, VA collections fell almost $200 million below projection targets. VA officials have acknowledged that there is no reliable methodology on which to base collections' projections, and no assurance that future projections can be achieved.

Under the Administration's budget, the availability of needed health care dollars are not simply dependent on VA employees' response to collections' incentives; factors completely beyond VA's control absolutely limit recovery potential. In a recent report to this Committee, the General Accounting Office cited a number of these factors as evidencing the likelihood that recoveries from private health insurance will actually decline. They include:

- the shift in care from inpatient to outpatient settings;
- increased enrollment in managed-care health-insurance plans;
- changes in how insurers process VA claims; and
- the aging and decline of the veteran population.

The Committee notes that, in contrast to the heady projections in the Administration's budget, the Congressional Budget Office baseline projects medical care collections of only $559 million for fiscal year 1999. In effect, this Administration asks the Congress to join its wager that VA will exceed the CBO collections' estimate by $118 million. It is particularly troubling that this wager accompanies an Administration budget request for medical care appropriations which, as discussed above, seeks *no funds* for uncontrollable increases in program costs, such as rent costs and mandatory salary increases, (totaling $419 million) and inflation ($262 million) and blithely looks to unidentified "management efficiencies" as a source for absorbing these costs. With such a dangerous balancing act ahead, Congress can ill afford to bet on OMB's collections' targets and risk a more than $100 million error.

Proposed legislation.—The Administration's FY 99 budget extends a wholly unprecedented offer to Congress. As proposed in the budget, if the Congress enacts legislation to authorize a "new smoking cessation program for any honorably discharged veteran who began smoking in the military . . . the Administration will submit a budget amendment requesting an appropriation of $87 million for this new activity." It is apparent to the Committee that the Department of Veterans Affairs did not initiate this request, and would be hard pressed to defend it as a priority.

The "smoking cessation" proposal is ill conceived. It ignores the existence of authority under current law to provide such services—as part of the care furnished veterans who enroll as VA patients. It proposes to spend substantial monies on a new benefit which, in practice, would have to be made available to any honorably discharged veteran. The proposal would draw a distinction, without explanation, between the honorably discharged veteran and veter-

ans with general discharges or other than dishonorable discharges, but would be open to veterans regardless of income. While making large numbers of veterans eligible for a limited, new benefit, the proposal is logically flawed in providing no other services for veterans who have or are presumed to be at risk for smoking-related illnesses. With VA only beginning to implement a 1996 law reforming the patchwork of law which had previously governed eligibility for VA health care, this proposal would reinstate the confusion inherent in a veteran being provided a service related to smoking but denied other smoking-related care or preventive services.

Unmet long-term care need.—While the Administration's budget proposes a new "medical" benefit for veterans, it does little to assure needed availability of care for those both eligible for, and dependent on, VA care. Specifically, this budget does little to narrow the gap between the needs of the aging veteran population and VA's capacity to meet their long-term care needs. While VA has extended its capacity to provide relatively low-cost primary care services to its patients, it has no comparable record of achievement in meeting long-term care needs—particularly in provision of services aimed at avoiding institutionalization. To the contrary, VA's Advisory Committee on the Future of Long-Term Care, in its deliberations over the past months, has identified VA's level of commitment to noninstitutional community-based long term care programs as in need of a dramatic infusion of funds.

Currently, only approximately seven percent of VA long-term care funding is devoted to noninstitutional long-term care programming, with almost 93 percent of funds devoted to provision of nursing home care. The small percentage dedicated to keeping patients in their homes and communities masks the reality that there is tremendous variability in expenditures from network to network. Thus, while a number of networks allocate some 10 percent of their long-term care budgets to community-based non-institutional care, several dedicate only half that much. Given a need for such services among the large numbers of VA's elderly chronically ill patients, it is apparent that VA has much catching up to do. The Advisory Committee, for example, discussed a proposal to triple VA funding for these programs. VA would need to boost spending by some $250 million to meet that target. The Committee believes that the $87 million proposed for smoking cessation programs would be better spent if those monies were allocated instead as a first step toward meeting aging and chronically ill veterans' widespread need for non-institutional services. Such added funding alone would provide no new services, however, if VA collections fall significantly below the budget estimates.

In testimony before this Committee, VA has also recognized a need to provide case-management services for veterans with complex health problems. Case management services are needed by a range of VA's patients, from the elderly, chronically ill veteran to Persian Gulf veterans with complex undiagnosed illnesses. This budget, however, is not only silent as to dedicating staff to address this need, it actually proposes a *reduction* in VA's health care workforce by 2,600 FTEE. With a staffing reduction projected to occur at the same time as a planned increase in patients treated, there is little basis to believe that medical centers will have suffi-

cient incentive or capacity to establish new case-manager positions. Yet such positions are needed to ensure that veterans in greatest need do not "fall through the cracks".

VA's resource allocation system (VERA) does provide its *networks* with higher per patient funding for special care patients, those suffering from such chronic conditions as schizophrenia and dementia, spinal cord injury, and AIDS, who are necessarily high intensity users of medical care. The General Accounting Office's audit of VA's implementation of VERA makes apparent, however, that there is no system or uniformity associated with the distribution of those funds by VA's networks to their VA medical centers. Such variability may be attributable to the competing pressures for funds within the networks. For example, networks are required to absorb the often high recurring and nonrecurring costs of construction activations. Moreover, there is no requirement on the networks that such special care funding support in full the needs of special care patients, and no evidence that they have been so used. In fact, recent testimony before this Committee suggests that they are not. Accordingly, the Committee is concerned that the closure of many inpatient programs and anticipated further reduction in employment levels will leave many networks without the capacity to support adequately the growing number of deinstitutionalized chronically mentally ill veterans and other chronically ill veterans with little or no community support mechanisms.

The Committee believes it is important and prudent in the face of further anticipated deinstitutionalization, that new monies and accompanying FTEE be targeted to ensure intense case-management programs for the most complex cases. The Committee believes this investment could ultimately avoid the need to reinstitutionalize patients. VA reports that it provides care to more than 146 thousand "special care" patients. Dedicating 980 FTEE to case management support could ensure closely supervised, coordinated care for some 10 percent of the most complex of cases within the special care population.

Accordingly, the Committee recommends an increase above the amount recommended by the Administration for appropriation to the medical care account of $481 million, encompassing the following:

- the addition of $118 million to cover the difference between CBO's projection of medical care collections in FY 1999 and VA's collections' target;
- $200 million to cover that part of the projected $681 million health-care cost increases and inflation which cannot reasonably be absorbed by "management efficiencies" without putting valued veterans' programs and services at risk;
- a reduction of the $87 million proposed for a smoking cessation program, and the addition of $95 million to expand community-based non-institutional long term care services; and
- $68 million to establish case-management programs at VA medical centers and large clinics.

Such an increase in the medical care appropriation would reduce the very large risks facing veterans who depend on the VA health

care system while enabling the Department to begin to expand much needed programs to care for the most vulnerable of VA's patients.

Medical Research

The $300 million fiscal year 1999 budget for medical and prosthetic research for the first time in many years recognizes the real value of this program, and the dangers in reducing VA's research efforts. The Department has designed well-developed strategies and performance goals for its research program which provide confidence that a historically strong effort will be both focused and provide maximum benefit. The Committee is pleased that in proposing a substantial increase over the fiscal year 1998 appropriation, this budget would allow for new initiatives in areas with particular relevance to veterans.

Major Medical Construction

As the VA health care system undergoes a significant transformation from providing care primarily in hospital wards to offering more outpatient services in an expanding number of both facility-based and community-based outpatient clinics, Congress expects VA to continue to rely on its expansive hospital-based infrastructure as a foundation for its clinical, education and research activities. Much of that infrastructure is decades old, and in many cases fails to meet patient care, safety, and privacy needs.

In recent years, constrained major construction budgets have resulted in fierce competition for scarce funding among projects with demonstrable compelling needs. As limited budgets have delayed approval of long pending initiatives, projects have undergone repeated scrutiny and reassessment. It is clear that VA's highest priority projects are well justified and are limited to addressing the most serious needs—to improve ambulatory care capacity, to remedy seismic problems, and to meet current patient care standards and requirements. It is troubling, that, with the backlog of worthy proposals, the Administration budget would fund only two major medical construction projects. While the Committee recognizes the need for these two projects, it finds very troubling this budget's failure to request funds for what the Department itself has identified as its three highest priority projects, ambulatory care additions to medical centers serving major metropolitan areas. The three projects, in Cleveland, Tucson, and Washington, D.C., would provide needed space for ambulatory treatment now furnished in buildings constructed for much smaller outpatient workloads 40 or more years ago. Similarly, the budget would not fund two other highly ranked projects, one at the Palo Alto, California VA Medical Center which Congress authorized in Public Law 104-262, and the other at the Dallas, Texas VA Medical Center.

Mindful of competing budget pressures, the Committee recommends a funding level of $237 million, a $140 million increase above the Administration's proposal.

While the Administration's budget clearly does not assign a priority to major medical construction, it is perplexing that greater priority is not given to either the minor construction program or to funding which supports the State home construction program.

Minor Construction

The minor construction account, funding initiatives of $4 million or less, supports a wide range of needs. Operating in facilities which are often many decades old, VA requires the flexibility provided by this account to correct safety deficiencies; replace utility, heating and cooling systems; meet patient privacy standards, including those dictated by the increasing number of women patients; renovate space for provision of ambulatory care; correct seismic deficiencies; clean-up environmental contamination and remove asbestos; and address other needs. Given growing, rather than diminishing, needs in the Department's huge infrastructure, it is difficult to understand a proposed cut of $34 million in this account. Extensive systemwide needs and the absence of any rationale for the proposed reduction, compel the Committee to recommend restoration of those monies and full funding at the current fiscal year level of $175 million.

State Home Construction

This program provides funding for up to 65 percent of the cost of construction or needed renovation to help assure that States can assist in meeting veterans' needs for nursing home and other long term care. The states have been reliable partners in this effort, and many have appropriated monies in advance to establish priority for grant funding in accordance with the governing statutory priority system. At this time, many states have already appropriated their share of construction costs (to establish priority #1 level ranking) for as yet unfunded construction projects, for a total of more than $112 million.

The fiscal year 1999 budget proposal to cut funding for this program by $43 million sends a strange signal to the VA' state partners. In the face of a large backlog of unfunded projects, it is unreasonable to cut funding by more than half. Rather than asking states which have put up their share of funding in advance to wait for outyear appropriations, the budget should reflect a commitment to eliminate the backlog as soon as possible. Accordingly, the Committee proposes an appropriation of $80 million for fiscal year 1999.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

The MAMOE budget funds the headquarters' operations of the largest health care system in the country. Congress looks to VA's headquarters not simply to set policy, but to achieve results. It expects the Under Secretary for Health to manage and oversee a system which is marked not only by its size but by its increasing complexity. The Under Secretary's headquarters staff would shrink by some 16 FTEE under the fiscal year 1999 budget. Such a cut would come at a time of growing concern about inconsistent management of VA programs.

VHA's streamlined headquarters staff is adequate in size to provide policy guidance within a system which vests network directors with broad authority for operations and oversight. It has become increasingly apparent, however, that with the limited role charted

for headquarters, there no longer exists adequate oversight, or capacity for oversight, of field activities. Quality management represents perhaps the most striking example of marked inconsistency throughout the VA health care system, and one which requires a far more active, vigilant headquarters' role. In a recent report on quality management in VHA, the Department Inspector General's Office of Healthcare Inspections highlighted this concern:

> "VHA has many QM policies and processes, which, *if applied consistently and effectively*, would assure the best possible treatment of VHA patients . . . VHA is challenged with having to ensure the operation of an effective QM program in what may be one of the largest and most complex healthcare systems in existence today . . . [However] VHA's process of devolving management functions to the lowest management level, and the emphasis that has been placed on performance measures . . . has led to a potential inability of top VA managers to know the status of QM implementation in the field. OHI believes that this may have occurred because of a diminution of QM-specific staff at the Headquarters and VISN levels, and because of the remaining employees' need to emphasize performance measurement. By implication, a weakened QM program . . . means that top managers cannot know definitively that VAMC practitioners are maintaining an adequate level of quality in patient care."

The Committee shares such concerns, and believes that a reduction in staffing would exacerbate the kinds of problems the Inspector General has highlighted. Based on these concerns, the Committee recommends an additional $2 million for this account to restore proposed staffing cuts and provide additional staff for quality management oversight.

The Committee recommends 20 additional staff, for a total of 560 employees for the Medical and Miscellaneous Operating Expenses account. These additional positions would be assigned to system-wide quality assurance programs in the Office of Quality and Performance and other appropriate areas reporting to the Under Secretary for Health. Such positions should monitor and enforce compliance of headquarters' quality-management directives; coordinate and monitor quality assurance activities, including VA's new Patient Safety Improvement initiative; and ensure timely access, analysis, and response to information collected from VHA's automated databases including clinical indicators of quality. New quality assurance employees should also be responsible for ensuring appropriate levels of credentialed, privileged and board-certified staff at each level of the organization.

VETERANS BENEFITS ADMINISTRATION

Operation of Benefit Programs

The General Operating Expenses account funds full time employee equivalents (FTEE) and operating expenses for both the Veterans Benefits Administration (VBA) and VA's Central Office (headquarters). VBA administers a broad range of non-medical benefits to veterans, their dependents, and survivors through 57 re-

gional offices or medical and regional office centers. These programs include compensation and pension, education, vocational rehabilitation, insurance, and loan guaranty (home loans). VBA is also responsible for processing applications for these programs. Headquarters includes the Secretary's staff and other VA support staff, and is mainly located in Washington, DC.

The Department proposes to reduce overall VBA staffing by 125 FTEE in fiscal year 1999, largely through reductions in information technology and support staff positions. The Committee does not support the proposal. This would be a decrease of 698 FTEE from the fiscal year 1997 actual employment level. The Committee recommends an increase of $15 million to support an additional 300 FTEE. These additional FTEE should be utilized in direct service positions and for quality review activities described below.

The Committee does not support the proposed reduction of FTEE because VBA's backlog of claims waiting to be processed is again increasing, approaching 400,000 claims. The situation is simply this: the funnel into which all the work is being poured is too small. The adverse effects of the overflow are a decline in the quality of work and employee morale. The Administration and Congress must recognize that benefit programs cannot be delivered effectively without sufficient well-trained staff.

To illustrate the Committee's concern about the quality of work being affected by FTEE reductions, VA recently completed its first Systematic Technical Accuracy Review (STAR). This review of a national sample of original compensation claims found that 36 percent of the claims contained at least one serious error. In that group of claims, errors average over four per claim. Clearly, this error rate is substantially higher than VA had ever acknowledged and the Committee highly commends VBA for its candor and willingness to finally document what most stakeholders had been saying for years. The Committee strongly believes this type of quality review must continue and recommends an additional 10 FTEE and $600,000 to continue this vital program.

Compensation & Pension Service(C&P).—The ability of the VA to provide timely and quality benefits delivery is heavily dependent on a combination of proper staffing levels, effective implementation of computer modernization initiatives, training and retention incentives, and inter-departmental cooperation between the various VA agencies and military service departments. Over the past decade the number of trained personnel in the adjudication division has declined by approximately 40 percent. The Committee commends the Department for reversing this trend with a 140 FTEE increase proposed for adjudication services in fiscal year 1999. As mentioned before, this increase comes largely from redistribution of resources within the C&P service and its related support staff. The net gain for the C&P Service following redistribution is seven FTEE. With processing time still averaging over 130 days for an original compensation claim, and remand rates from the Board of Veterans' Appeals (BVA) still approaching 50 percent of the Board's decisions, the Committee supports the 140 FTEE increase in the C&P Service proposed in fiscal year 1999. The Committee also recommends 100 FTEE be added to the C&P Service from the 300 FTEE in overall VBA employment recommended by the Committee.

Computer Based Training Initiative.—The Committee commends the VBA for developing an innovative approach to computer based training in a cooperative adult learning environment. The initial training module developed for certifying a case to the BVA has been completed and will be implemented during the current fiscal year. The development of additional training modules is expected to reduce the time necessary to train key VA decision-makers by at least 50 percent. Given the anticipated savings in cost and improved performance by well-trained employees, the Committee believes that the development of additional computer based training materials should be accelerated and recommends an additional $6,000,000 for this purpose.

Vocational Rehabilitation and Counseling Program (VR&C).—The goal of the Vocational Rehabilitation and Counseling Program is employment of disabled veterans and certain dependents. To accomplish that goal, VR&C is authorized to provide all services and assistance necessary to enable service-connected disabled veterans to become employable, obtain and maintain suitable employment, or to achieve maximum independence in daily living. Additionally, VR&C is authorized to provide educational and vocational counseling services to eligible active duty members, veterans, and dependents. Last year, about 9,000 veterans were rehabilitated and VA projects a slight decline in program participants from 1997 and 1998 levels. Vocational rehabilitation specialists currently carry an average caseload of about 300 and the small decline in overall participation will not measurably affect the average.

The General Accounting Office has issued three reports since 1984 citing significant program management problems, such as an inability to identify program costs, high drop-out rates, poor case management and an almost blanket use of college degree programs for rehabilitation. The Committee expects VR&C to pursue a more integrated working relationship with the Veterans' Employment and Training Service and implement several recent management initiatives until these significant problems are overcome. While the Committee is supportive of the budget's additional 12 FTEE for the Vocational Rehabilitation and Counseling Service, the Committee notes that this is about 26 FTEE below the 1997 actual employment level for the VR&C Service. The VA estimates that an additional 87 FTEE would be required to enable VR&C staff to eliminate its backlog of cases and provide an adequate level of services.

Education Service.—VA's Education Service is responsible for several programs, most notably the Montgomery GI Bill (MGIB), which provides earned education assistance benefits to 400,000 veterans, active duty, and National Guard and Reserve personnel, as well as programs for survivors of veterans who are 100 percent disabled, died of a service-connected disability or were killed on active duty.

The Committee rejects the proposed reduction of 25 FTEE for the Education Service in the President's fiscal year 1999 budget. Such reductions will result in a lower level of service to veterans because automation and business process reengineering initiatives are not yet mature enough to sufficiently increase administrative efficiencies.

The Committee finds it surprising that VA has not implemented an electronic method of monthly certification of enrollment, which would eliminate nearly all of the, three weeks required at a minimum to process monthly education benefits. The Committee estimates that postal savings alone will pay for the system within two years. The Committee also supports the requested $4.5 million for the automation of education program management.

BOARD OF VETERANS' APPEALS

The Board of Veterans' Appeals (BVA) has made progress toward meeting the production levels needed to reduce the backlog of appeals pending. The fiscal year 1996 backlog of over 60,000 appeals has now been reduced to under 35,000 as a result of additional resources provided over the past two years, as well as several management initiatives. In fiscal year 1997, the BVA made over 43,000 decisions, an increase of 10,000 over the previous year. Unfortunately, 42 percent of those decisions were remands back to the regional offices, another example of the quality problems that continue to plague the Regional Offices.

Clearly, production trends are improving at the BVA and the Committee notes that BVA total processing time for all categories of claims was reduced from 1,146 days in fiscal year 1996 to 1,027 days in fiscal year 1997. The Administration has requested an additional three FTEE to serve as counsel to the Board members and the Committee supports that request. An independent consultant retained to study the processes used internally by the Department to prepare cases appealed to the United States Court of Veterans Appeals has suggested that the Board should prepare an appellate record as it reviewed each case on appeal. The Committee also notes that there is a substantial backlog of cases where veterans have requested personal hearings by the Board near their residence. Since additional staff are needed to address both of these situations, the Committee is recommending an additional $1 million for the Board's operations in fiscal year 1999.

INSPECTOR GENERAL

Over the past five fiscal years (FY 1993–97), OIG audits and inquiries identified cost savings and cost avoidance in excess of $1.6 billion. This represents an average rate of return of $10 for every $1 spent by the OIG. Despite the efficiencies which stem from the work of the OIG, there is a significant amount of important work which the Office of Inspector General (OIG) cannot accomplish with the resources it has available today and under the proposed 1999 budget. Present staffing levels are inadequate to meet present department needs. Therefore, the Committee recommends an additional $3 million for increased OIG staffing. The increased OIG funding provided in the Committee's budget represents a sound investment strategy which will help identify waste, fraud and abuse within the VA, and save VA money in the process.

NATIONAL CEMETERY SYSTEM

The National Cemetery System (NCS) administers national shrines honoring those who served in uniform and should be main-

tained as places of high honor, dignity and respect. Currently, 149 cemeteries and soldiers' lots located in 41 states, the District of Columbia and Puerto Rico comprise the National Cemetery System. Since the first cemeteries for American soldiers were established in 1862, approximately 2.4 million decedents have been interred in national cemeteries and approximately 6.4 million headstones and markers have been furnished.

For fiscal year 1999, the Administration is proposing an increase of $7.8 million to fund NCS's ever-enlarging operations. This includes funds for 21 additional FTEE to accommodate increased workloads throughout the system as well as staffing for a new cemetery in Tahoma, Washington, and start-up staffing for new cemeteries being constructed near Chicago, Illinois; Dallas, Texas; and Albany, New York. The Committee is in full support of the Administration's request for an additional $7.8 million, including 21 FTEE, for the National Cemetery System.

Between fiscal years 1995 and 2010, the veteran population will decrease by six million (23 percent). As a result, NCS faces an increasing workload because many families of the remaining 7.5 million veterans of the World War II generation will seek burial in a national cemetery. The NCS's workload per FTEE will continue to grow in all areas of operations. For example, the total number of gravesites and acreage maintained will increase every year. The number of headstones and memorial certificates delivered will also increase. In fiscal year 1997, the VA interred 73,786 veterans and family members. In fiscal year 1999, VA expects to inter 80,300 and by the year 2003, the number of interments is projected to increase to 93,600. The VA also expects to process 342,000 grave marker applications in fiscal year 1999. NCS must have both human and material resources to accommodate these increases. Similarly, the number of gravesites maintained is estimated to exceed 2.3 million in fiscal year 1999.

National Cemetery System Operating Account

The Committee is pleased that VA is proposing to increase funding by $1.5 million for maintenance and repair, grounds maintenance and related supplies. These funds are vital to preserving the appearance of the cemeteries. The Committee recommends an additional $1 million to accelerate the improvements of the System's appearance.

The National Cemetery System maintains approximately 400 buildings and 100 miles of roads. To help with that maintenance, VA has an inventory of more than 8,000 pieces of equipment with an estimated value of $23 million, approximately $7.2 million of which is past due for replacement.

Cemetery Construction

The VA's construction needs for new and existing cemeteries are addressed through Major and Minor Construction appropriations. NCS has focused construction planning on providing new cemeteries in areas of the country with the greatest unserved veteran population, extending the life of existing cemeteries through gravesite development, and repairing and maintaining the infrastructure of the system. The Committee notes there are no funds

requested for additional new cemeteries beyond the four scheduled to open through 1999. The Committee recommends that of the additional funds recommended for VA construction, $500,000 be used for planning efforts to identify sites for additional NCS cemeteries.

The Administration's fiscal year 1999 proposal contains $12 million in major construction projects for columbaria at the Florida and the Ft. Rosecrans, California, National Cemeteries. The Committee fully supports those proposals.

Minor construction projects, which are those costing less than $3 million, total $14 million for fiscal year 1999, and the Committee supports that request.

State Cemetery Grants Program

The State Cemetery Grants Program provides grants to assist the states in establishing, expanding, and improving state-owned veterans cemeteries. The State Cemetery Program is funded at $10 million for fiscal year 1998. Since its establishment in 1980, $57.6 million has been obligated through fiscal year 1997. Nearly 100 grants have been awarded to 25 states, Saipan and Guam since the program's inception. The Committee supports sufficient funding to accommodate any state seeking to participate in the State Grants Program.

Arlington National Cemetery

Arlington National Cemetery is the nation's premier resting place for veterans. The cemetery is currently the final resting place for over 250,000 remains. In fiscal year 1999, Arlington Cemetery officials estimate they will add about 5,600 remains to that total, and conduct 2,700 non-funeral ceremonies.

The Administration's request is $150,000 below the fiscal year 1998 appropriation. The Committee does not support that request and recommends an additional $1 million to support operations and maintenance at Arlington National Cemetery.

U.S. Court of Veterans Appeals

The Veterans' Judicial Review Act, Public Law 100-687, established the U.S. Court of Veterans Appeals as an executive branch court. The Court is empowered to review decisions of the Board of Veterans' Appeals and may affirm, vacate, reverse or remand such decisions as appropriate. The Court has the authority to decide all relevant questions of law, to interpret constitutional, statutory, and regulatory provisions, and to determine the meaning or applicability of the terms of an action by the Secretary of Veterans Affairs. The Court also has the authority to compel actions of the Secretary that are found to have been unlawfully withheld or unreasonably delayed.

The Committee supports the Court's budget request of $10.2 million.

Department of Labor

VETERANS' EMPLOYMENT AND TRAINING SERVICE

Congress has determined that our nation has a responsibility to meet the employment and training needs of veterans. To accom-

plish those goals, the Assistant Secretary of Labor for Veterans' Employment and Training (ASVET) is authorized to implement training and employment programs for veterans. The ASVET also acts as the principal advisor to the Secretary of Labor with respect to the formulation and implementation of all departmental policies and procedures which affect veterans.

The Committee is aware of the significant changes in the national labor exchange system. States are changing the way they deliver employment services and adopting new service delivery models ranging from devolving state programs to the county level to privatizing some or all employment functions and instituting one-stop employment centers.

Since the Veterans' Employment and Training Service (VETS) and its state-based Disabled Veterans Outreach Program Specialist (DVOP) and Local Veterans Employment Representative (LVER) system depends upon the state employment services, VETS must adopt new strategies to deliver employment services to veterans. During the next year, the Committee expects the Department of Labor to provide a plan to evolve the veterans' employment system to function effectively in the new labor exchange marketplace.

Disabled Veterans' Outreach Program

Under section 4103A, title 38, United States Code, the Secretary of Labor is required to annually make available sufficient funds for use in each state to support the appointment of one DVOP specialist per 6,900 veterans of the Vietnam era, veterans who entered active duty as a member of the armed forces after May 7, 1975, or service-disabled. For fiscal year 1999, this formula results in 2,082 DVOPS. However, the Administration's budget provides funds to support only 1,440 DVOP positions, 641 below the Congressionally-mandated level. Accordingly, the Committee recommends that an additional $36,065,000, for a total of $116.1 million, be provided for the DVOP program. The Committee notes that this full funding level will result in an estimated 50,000 additional veterans placed in jobs.

The Disabled Veterans' Outreach Program (DVOP) provides intensive employment and training services to service-connected disabled veterans and other veterans in need of job search and placement assistance. DVOPs serve as workshop facilitators for the Transition Assistance Program (TAP), a 3-day program that provides transition counseling, job-search training and information, placement assistance and other information and services to servicemembers who are within 180 days of separation from active duty. DVOPs also develop job and job-training opportunities for veterans through contacts with employers. Additionally, DVOPs provide assistance to community-based organizations and grantees who provide services to veterans under other federal and federally-funded employment and training programs, such as the Job Training Partnership Act and the Stewart McKinney Act.

Local Veterans' Employment Representatives

Section 4104(a)(1), title 38, United States Code, mandates that the Secretary of Labor make available funding to support the appointment of at least 1,600 full-time LVERs and the states' admin-

istrative expenses associated with the appointment of that number of LVERs. The Committee supports full funding at the statutorily-mandated level of $96.7 million for the 1,600 positions, an increase of $19,622,000 over the funding level proposed in the Administration's budget. VETS estimates that the additional 300 LVER positions provided by full funding will result in 50,000 more veterans being placed in jobs.

The Local Veterans' Employment Representative (LVER) program was established to functionally supervise the provision of job counseling, testing, job development, referral and placement to veterans in local employment services offices. LVERs participate in TAP workshops and maintain regular contact with community leaders, employers, labor unions, training programs and veterans service organizations in order to keep them advised of eligible veterans available for employment and training. LVERs also provide labor exchange information to veterans and promote and monitor participation of veterans in federally funded employment and training programs. Finally, LVERs monitor the listing of jobs by federal contractors and subsequent referrals of qualified veterans to these employment openings, refer eligible veterans to training, supportive services, and educational opportunities, and assist, through automated data processing, in securing and maintaining current information regarding available employment and training opportunities.

VETS also manages the Homeless Veterans Reintegration Program (HVRP). The program is designed to provide support services to local agencies targeting homeless veterans with employment assistance. For the past two years, the President and the Appropriations Committee have failed to support funding for the program, while the law creating this program authorizes $10 million per year. This year the President has proposed $2.5 million for HVRP. The Committee recommends funding HVRP at the authorized level of $10 million to increase services to homeless veterans.

National Veterans Training Institute

The National Veterans Training Institute (NVTI) is operated under contract by the University of Colorado at Denver and provides basic and advanced instruction in veterans employment programs and services. Because this is the only source of formal training for federal and state employees for veterans employment programs, NVTI is vital to the success of those programs. The President has recommended $2.0 million for fiscal year 1999 and the Committee fully supports that request.

Proposed Legislation

Cost of Living Adjustment (COLA).—The Committee supports a cost-of-living adjustment (COLA) for compensation and Dependency and Indemnity Compensation, and education recipients equal to the COLA calculation for Social Security recipients.

LEGISLATIVE ITEMS WHICH THE VA COMMITTEE MAY REPORT WITH SMALL DIRECT SPENDING IMPLICATIONS

Extend expired authority to allow VA medical center retention of certain pension benefits payable to veterans who are being provided nursing home care at VA expense.—Veterans without dependents who are being provided nursing home care by the Department and who receive pension benefits have the amount of their pension reduced to $90 per month after three calendar months of nursing home care. The VA facility providing the medical care had the authority to retain amounts of pension above $90 which would otherwise be paid to the pensioner and to use those funds for operating expenses. This authority expired on September 30, 1997. The Committee estimates the first year cost of reinstating this authority at $2 million and the five year cost at $11 million.

H.R. 3039, Transitional Housing for Homeless Veterans.—The bill would authorize VA to guarantee loans made to providers of transitional housing for homeless veterans. The number of projects is limited to 15 and the total amount of loans guaranteed is limited to $100,000,000.

The Committee estimates the first year cost at $1 million and the five year cost at $7 million.

Increase Auto Allowance and Specially Adapted Housing Allowance for Severely Disabled Veterans.—VA is authorized to provide a one-time reimbursement to severely disabled veterans of $5,500 for the cost of an automobile. This amount has not changed since 1988, while the cost of a new automobile has increased to nearly $22,000 in 1997. VA also provides a grant to offset the cost of purchasing or modifying a home to accommodate a veterans' disabilities. The current benefit level of $38,000 was set in 1988.

The Committee estimates the first year cost at $7 million and the five year cost at $34 million.

H.R. 1877, Extend VA work study authority.—VA authorizes institutions such as colleges and other government programs to hire veterans to assist with veterans-related work. The program pays the higher of the federal or state minimum wage. The Committee has introduced legislation to broaden the organizations eligible to apply for work study positions.

The Committee estimates the first year cost at $1 million and the five year cost at $5 million.

COMPENSATION FOR TOBACCO-RELATED ILLNESSES

As part of its fiscal year 1999 request, the Department of Veterans Affairs submitted a legislative proposal to limit compensation for tobacco-related illnesses to those who contract such illnesses on active duty or within the standard one year presumptive period following service. However, the Administration only proposes spending about $1.5 billion (9 percent) of the OMB-estimated $16.9 billion in savings to improve three veterans' benefit programs. The Congressional Budget Office estimates savings from enacting such legislation at $10 billion over five years.

VA has begun processing and paying service-connected disability compensation for tobacco-related illnesses as a result of a 1997 de-

cision by the VA General Counsel. The General Counsel's decision held that if a disease or death can be shown to be a result of nicotine addiction acquired in military service, service-connected compensation is warranted.

Following that decision, in a May 9, 1997, letter to the Speaker accompanying the legislative proposal, former VA Secretary Jesse Brown stated that such payments could cause a loss of public support, thereby threatening the integrity of the veterans disability compensation system. The Committee concurs with former Secretary Brown's concerns about the integrity of the compensation system. The Committee also believes that paying compensation to veterans for tobacco-related illnesses goes beyond the government's responsibility. There is a significant philosophical difference between service-connected compensation and other disability programs such as Social Security or the VA pension program which make no distinctions based on when a disability or illness occurs or is first diagnosed. Service-connected compensation, on the other hand, is based on the presumption that a person would not have the illness or disability save for some event or circumstance beyond the person's control. A policy of paying compensation for tobacco-related illnesses absolves the veteran of personal responsibility for his or her choices about tobacco use. In the past, Congress has determined that the individual, not the federal government, is responsible for illnesses which are related to the use of alcohol or drugs. Thus, a policy of paying benefits for illnesses related to the use of tobacco would be inconsistent with these prior determinations.

The Committee is also very concerned that the projected annual caseload of 540,000 tobacco-related claims would overload the adjudication system and lengthen the already-too-long processing time for all types of claims. VA estimated in 1997 that processing time for an original compensation claim would increase from 113 days to 312 days.

To reflect the nation's commitment to its veterans, the Committee will recommend legislation that will use all of the savings from enacting a limitation on compensation for tobacco-related illnesses to improve a wide range of programs. These are programs affecting our most disabled veterans, surviving dependents, separating service members, unemployed and under-employed veterans, and those seeking an education or a home.

Although the Committee is still considering a number of benefit enhancement proposals, the Committee has made it clear that an increase in the Montgomery GI Bill is warranted and long overdue. Therefore, to implement a 40 percent increase in the basic education benefit payment over the next two fiscal years, the Committee recommends a 20 percent increase in the Montgomery GI Bill benefit for fiscal year 1999 and a 20 percent increase for fiscal year 2000. This would be the most significant increase in veterans' education benefits since the Montgomery GI Bill was enacted in 1985 and would decrease the gap between the cost of higher education and the level of benefits due to inflation in education costs.

The cost of education has increased at over seven percent per year since the inception of the Montgomery GI Bill. Today a veteran with two years of honorable military service receives a maxi-

mum basic benefit of $3,213 for a nine month school year, from the Montgomery GI Bill (MGIB). But the average annual cost in 1996 for tuition, room and board, fees, books and transportation at a public institution was $10,759, a total increase of 109 percent since 1987. For private schools, the annual cost is now $20,003, an increase of 84 percent since 1987.

As a result, the Montgomery GI Bill falls short by $7,546 annually for a public school and $16,790 for a private school. By way of comparison, the current AmeriCorps education benefit of $4,725 per year for two years exceeds the earned MGIB basic benefit on a per school year basis by $1,512. In addition, persons participating in Americorps are also eligible for additional benefits such as health care and child care.

Further, GI Bill benefits count as income or resources when calculating a veterans' eligibility for all other federal education assistance programs. In stark contrast, AmeriCorps benefits do not count against other federal education grant and loan programs. As a result, because of their GI Bill benefits, veterans are often eligible for less federal financial aid than their non veteran contemporaries.

ADDITIONAL AND DISSENTING VIEWS

"Particularly onerous is a legislative proposal to repeal the VA's authority to pay compensation to veterans or their survivors for disabilities related to tobacco use in military service. The 'savings' from denying compensation to those veterans and their families would then be used to boost spending for other non-VA programs. Such a proposal is an irrational reversal of policy. I find it totally unfair and unjustified to pillage veterans programs . . . ". Arthur H. Wilson, National Adjutant, Disabled Veterans of America, DAV Magazine, March / April, 1998.

On the proposal to enact legislation to significantly preclude the granting of service-connection for tobacco-related illnesses, the National Adjutant of the Disabled American Veterans unquestionably speaks for millions of his fellow veterans. As a matter of principle, the Administration's proposal to enact legislation to significantly limit the granting of service-connection for disabilities related to initial tobacco use in military service and a resulting nicotine addiction is rejected.

In defending its proposal, VA has stated that the denial of service-connected compensation to veterans for smoking related illnesses resulting from a nicotine addiction developed in service is needed to preserve the integrity of the VA compensation system. In fact, the opposite is true. The integrity of VA's compensation system will be undermined if Congress were to enact new legislation prohibiting service-connected compensation for smoking related illnesses.

This is also an issue of equity for veterans. Social Security programs provide income for individuals with tobacco-related disabilities. Once a disability is determined to be chronic (having a long-term effect on an individual's ability to re-enter the workforce), Social Security Disability Insurance is provided for disabled workers with an adequate number of work credits. Supplemental Security Income is a needs-based program for those disabled persons who have long-term illnesses and limited income and resources. These programs do not attempt to base eligibility for those with smoking-related disorders on a different set of criteria than exists for other disabilities. Neither should VA base its compensation for smoking-related compensation on factors other than those it establishes for others with service-connected disorders.

As noted in the Committee's report, the Administration has assumed "savings" of $17 billion from enactment of this proposed legislation, but only $1.5 billion of these savings (or less than ten percent of these resources) are proposed to be used to enhance veterans benefits and service. Denying earned benefits to our Nation's veterans is injurious; using those "savings" to enhance non-veteran programs adds insult to that injury. While estimates of "savings" expected from enactment of the Administration's proposed legislation vary significantly, if such legislation were to be enacted, all "savings" should be used to enhance veterans benefits and services, as the Committee's report has noted.

The benefit increases for the Montgomery GI Bill education program and the Survivors' and Dependents' Education program included in the Administration's budget request for fiscal year 1999

are long overdue, demonstrably needed, and strongly supported on their own merit. The real value of these programs has been eroding for years as the costs of education have soared. The needs of veteran students have been ignored for too long. However, the Administration's proposed linkage between the recommended increase in VA educational benefits and the enactment of controversial legislation to repeal existing authority to provide compensation for tobacco-related disabilities should be rejected. Our veteran students have more than earned their right to meaningful educational assistance through their service in America's Armed Forces. The education benefit increases included in the Administration's proposed budget are the right thing to do. The proposed increases in veterans' education benefits should be provided by a grateful Nation with no gimmicks or strings attached.

If Congress were to accept the Administration's artificial and inappropriate linkage of veterans' education benefits and veterans' compensation, it will not only be breaking faith with America's veterans, but also would potentially establish a frightening precedent. Which existing veterans benefit will Congress be called on to reduce or repeal next in order to provide a meritorious increase for another benefit program? Which veterans or dependents will next be forced to forego current benefits so the benefits of other veterans can be enhanced?

In its proposed fiscal year 1999 budget, the Administration has proposed legislation to pay full disability compensation benefits to Filipino veterans and their survivors residing in the United States. Currently, these veterans and survivors receive benefits at one-half the amount their U.S. counterparts receive. The Administration's proposal is strongly supported and recommended.

Finally, for the record, it should be noted that the increase in VA research funding, which the Committee is pleased to recommend for next fiscal year, was proposed by the Administration. In this respect, the Committee should give credit where credit is due.

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